Sterling Lebanon Packaging Corporation *and* United Steel Workers of America International Union and its Local 175G, AFL–CIO, CLC. Case 6–CA–27846

September 12, 2000

DECISION AND ORDER

BY CHAIRMAN TRUESDALE AND MEMBERS FOX AND HURTGEN

On July 10, 1997, Administrative Law Judge Martin J. Linsky issued the attached decision. The General Counsel filed exceptions and a brief in support and the Respondent filed an answering brief.

The Board has delegated its authority in this proceeding to a three-member panel.

The National Labor Relations Board has considered the decision and the record in light of the exceptions and briefs and has decided to affirm the judge's rulings, findings, and conclusions and to adopt the recommended Order.[1]

ORDER

The recommended Order of the administrative law judge is adopted and the complaint is dismissed.

Sandra Beck Levine, Esq., for the General Counsel.
E. Donald Ladov, Esq., of Pittsburgh, Pennsylvania, for the Respondent.
Roy Albert, International Representative, of Pittsburgh, Pennsylvania, for the Charging Party.

DECISION

STATEMENT OF THE CASE

MARTIN J. LINSKY, Administrative Law Judge. On January 31 and October 1, 1996, the charge and first amended charge were filed against Sterling Lebanon Packaging Corporation, the Respondent.

On October 1, 1996, the National Labor Relations Board, by the Regional Director for Region 6, issued a complaint which alleges that Respondent violated Section 8(a)(1) and (5) of the National Labor Relations Act (the Act), when it failed to continue in effect all the terms and conditions of its collective-bargaining agreement with the Union by unilaterally including therein and making available to its employees a third managed care health plan not contained in the agreement and when it bypassed the Union and dealt directly with its employees in the unit by soliciting employees to enroll in the third health plan.

Respondent filed an answer in which it denied that it violated the Act in any way.

A hearing was held before me in Pittsburgh, Pennsylvania, on February 28, 1997.

On the entire record, to include posthearing briefs submitted by the General Counsel and Respondent, and on my observation of the demeanor of the witnesses, I make the following

FINDINGS OF FACT

I. JURISDICTION

At all material times Respondent, a corporation, with an office and place of business in Jeannette, Pennsylvania, has been engaged in the manufacture and nonretail sale of folding boxes and other packaging materials.

Respondent admits, and I find, that at all material times it has been a employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act.

II. THE LABOR ORGANIZATION INVOLVED

Respondent admits, and I find, that at all material times the United Steelworkers of America International Union and its Local 175G AFL–CIO, CLC (the Union), have been labor organizations within the meaning of Section 2(5) of the Act.

III. THE ALLEGED UNFAIR LABOR PRACTICES

For many years Respondent has recognized the Union as the exclusive collective-bargaining representative of its production and maintenance employees. This recognition has been embodied in successive collective-bargaining agreements, the most recent of which was effective from April 15, 1992, to April 16, 1995, and was extended by agreement of the parties to April 14, 1998.

Article 2, section 4 of the collective-bargaining agreement described above provides as follows:

> This agreement cannot be modified, amended or added to or subtracted from except by agreement in writing signed by the Company and both the International Union and Local Union.

Article 36 of the collective-bargaining agreement provides as follows:

> ARTICLE 36
> HOSPITALIZATION-MEDICAL-SURGICAL
>
> *Section 1.* During the term of this contract, the Company will provide to the employees a hospitalization insurance plan for employees and their dependents for 120 days of hospital care in a semi-private room each calendar year for each qualifying person.

[1] In dismissing the complaint, we observe that the General Counsel alleged that the Respondent failed and refused to bargain in good faith with the Union "within the meaning of Section 8(d) of the Act" by unilaterally introducing a third health benefit plan (which we find, in agreement with the judge, was an HMO) in addition to the Indemnity Plan and the Keystone HMO Plan previously available under the contract. As explained in *Mead Corp.,* 318 NLRB 201, 202 (1995), "Section 8(d) of the Act provides that a party which seeks to modify a term or condition of employment 'contained in' a current collective-bargaining agreement must obtain the consent of the other party before implementing the change." Here, the General Counsel contends that art. 36, sec. 13, of the contract, which provides that "[e]mployees are entitled to enroll in a Health Maintenance Organization (HMO)," limits to one the number of HMOs that the Respondent may offer to its employees at any given time. Contrary to the General Counsel, we find that art. 36, sec. 13, is ambiguous and does not, on its face, preclude the Respondent from introducing employees to more than one HMO plan. In these circumstances, the burden was on the General Counsel to clarify the ambiguity by the introduction of extrinsic evidence. We find that the General Counsel has not met that burden here.

Section 2. The benefit level for medical-surgical shall be usual and customary for the employees and their dependents. There shall be a $100 deductible per year for each insured family member for all Blue Shield (medical-surgical) charges.

Section 3. The Company will provide to the employee major medical insurance of $250,000.00 with $300.00 deductible per person per year, $900.00 maximum per family, per year.

Section 4. Those employees who are enrolled in either the family or the husband/wife categories shall be entitled to terminate their health insurance coverage and receive $1,000 per year in equal monthly installments from the Company provided that they have access to coverage which is equivalent to or better than the Company's.

Section 5. The Company will provide for the employees and their dependents at no cost to the employees, a diagnostic x-ray and laboratory benefits payment of usual and customary. There shall be a $300 deductible for each family member for each in-hospital admission and a $25 deductible for every hospital visit, out patient service, including emergency room.

Section 6. The Company agrees that all hospitalization-medical-surgical benefits shall be maintained at not less than the highest standard in effect at the time of the signing of this Agreement.

Section 7. Coverage for an employee and his eligible dependents will continue during the period an employee is laid off up to a maximum of two (2) months following the month in which the employee was laid off.

Section 8. The Company will pay the full premium for hospitalization for a twelve (12) month period for employees who are unable to work due to sickness or accident. Thereafter, they may continue to carry their coverage by paying the full group rate.

All employees desiring the Company Hospitalization-Medical-Surgical plan shall make the following monthly contribution:

INDIVIDUALS	TWO PERSONS	FAMILY (3 OR MORE)
$6.00	$10.00	$12.00

Section 9. Coverage for employees who are on leave of absence will cease at the end of the month in which the leave commences. However, employees on such leave may continue the coverage for the duration of the leave of absence by payment in full of the monthly premium.

Section 10. Employees who have completed their probationary period shall be eligible for hospitalization-medical-surgical insurance benefits as provided for in this Agreement and subject to Section 12 herein.

Section 11. Employees are eligible for a "change of status" on their coverage if there is a change in their family status.

Section 12. The Employer shall provide for new employees (hired after 4–15–92), when eligible, individual hospitalization-medical-surgical benefits only. Said new employees may purchase additional coverage for his/her dependents at the applicable group rates.

Section 13. Employees are entitled to enroll in a Health Maintenance Organization (HMO), if they so choose, for their health coverage. The Company will pay the monthly cost of the HMO up to, but not exceeding, the monthly cost of the Company provided hospitalization plan.

Section 14. The Employer will pay the entire first year increase (Oct. 1, 1992—Sept. 30, 1993) in hospitalization-medical-surgical premiums;

The Employer will pay a maximum of a 10 percent increase in hospitalization-medical-surgical premiums in the second year (Oct. 1, 1993 to Sept. 30, 1994). The 10 percent maximum will be calculated by taking the total first year costs of all hospitalization-medical-surgical premiums, including HMO and buy-out costs, divided by the total number of hours worked during the first year to determine a composite average hourly cost for all employees. The proposed monthly increases shall then be substituted for the first year costs and annualized and the Company shall pay a maximum 10 percent increase over the first year cost.

The Employer will pay a maximum of a 10 percent increase over and above its second year cost of hospitalization-medical-surgical premiums in the third year (Oct. 1, 1994 to Sept. 30, 1995). The method to determine the second year cost as outlined above shall be used to calculate the Company's obligation in the third year.

If the premium increases exceed 10 percent in either the second or third year, the parties agree to meet to reduce benefits to contain costs, add deductibles and/or increase employee contributions to pay for such increases.

It is clear that the employees under the collective-bargaining agreement have a choice in health insurance plans between an indemnity plan spelled out in great detail in sections 1 through 12 of article 36 and a health maintenance organization (HMO) plan spelled out with little or no specifics in section 13 of article 36.

Section 13 of article 36 provides that "Employees are entitled to enroll in *a* Health Maintenance Organization (HMO), if they so choose for their health coverage." (Emphasis added.)

As a matter of fact only one HMO plan was offered to the employees at the time the contract went into effect. The HMO offered was the Keystone HMO. The cost of the Keystone HMO was community rated.

There came a time in 1995 when Respondent found out about another HMO plan which was being offered by Blue Cross-Blue Shield which was called the Blue Cross-Blue Shield Point of Service plan or Select Blue. The Indemnity plan and the Keystone HMO are also Blue Cross-Blue Shield products. It had not previously been available. At or about this same time Respondent learned that the costs of the health insurance Respondent offered its employees was going up approximately 17 percent.

The benefits to those enrolled in the Blue Cross-Blue Shield Point of Service plan were better than the benefits under the

Keystone HMO, i.e., the benefits were exactly the same under both plans but if enrolled in the Blue Cross-Blue Shield Point of Service plan there was some coverage if the covered employee went out of network to a doctor or medical provider not in the plan whereas under the Keystone HMO there was no coverage at all if a covered employee went out of network. The doctors, etc., who were "in network" were the same under both the Blue Cross-Blue Shield Point of Service plan and the Keystone HMO plan.

The cost of the Blue Cross-Blue Shield Point of Service plan to Respondent would be lower than the cost of the Keystone HMO plan because the cost was based partially on Respondent's own experience versus being totally community rated like the Keystone HMO.

In October and November 1995, Respondent met with the Union and urged the Union to agree that Respondent could drop both the Indemnity plan and the Keystone HMO and have its employees covered by just the Blue Cross-Blue Shield Point of Service plan. The Union wanted to share in any savings Respondent would realize from this and when the Respondent refused to share any of the savings with the Union the Union refused to go along with this change. Respondent agreed it could not do what it wanted to do on this score without the consent of the Union. Indeed had the Respondent dropped the Indemnity and Keystone plans and unilaterally modified the contract to provide *only* the Blue Cross-Blue Shield Point of Service plan to its employees this would have been a violation of Section 8(a)(1) and (5) of the Act. See *St. Vincent Hospital,* 320 NLRB 42 (1995).

Thereafter, in January 1996, Respondent unilaterally and over union objection offered to its employees during the life of the collective-bargaining agreement the option of switching from the Indemnity plan or the Keystone HMO into the Blue Cross-Blue Shield Point of Service plan. No one was required to switch.

The record reflects that 42 out of the 110 employees in the unit voluntarily elected to switch to the Blue Cross-Blue Shield Point of Service plan.

The record further reflects that any employee is eligible at any time to switch to any of the three plans or if they switched to the new Point of Service plan they are eligible to switch back to either the Indemnity plan or the Keystone HMO plan. The employees, in other words, are free to switch back and forth and there are no time limits on doing so and *no* preexisting medical condition will limit their right to transfer from one plan to another.

The Keystone HMO plan and the Blue Cross-Blue Shield Point of Service plan are both HMOs or managed care type plans. Since the collective-bargaining agreement provided in section 13 of article 36 that employees could enroll "in *a* Health Maintenance Organization (HMO), if they so choose" (emphasis added), I see no modification of the contract by Respondent if they offer two or more separate HMOs from which the employee can select "a Health Maintenance Organization (HMO)" as called for in the collective-bargaining agreement.

I note that the Union did not file a grievance over this matter and that at the hearing before me Respondent would not waive the time limits for filing a grievance so that this dispute could proceed to arbitration. Accordingly, this is not an appropriate case for deferral to the arbitral process. See *United Technologies Corp.*, 268 NLRB 557 (1984).

The expansion of the number from one to two of the HMOs in which employees can enroll does not modify the collective-bargaining agreement since employees can enroll still in either the Indemnity plan or an HMO. Accordingly, no violation of Section 8(a)(1) and (5) of the Act occurred when Respondent unilaterally and without consent of the Union offered a second HMO option to its employees in the unit.

If the Blue Cross-Blue Shield Point of Service plan is *not* an HMO, which I find it is, then the offering of the Point of Service plan in addition to the other two plans would be a mid-term modification done without the required union consent and, therefore, a violation of Section 8(a)(1) and (5) of the Act. However, I find that the Blue Cross-Blue Shield Point of Service plan is an HMO. I do so because James Hinerman, a sales executive for Blue Cross-Blue Shield, described the Point of Service plan or Select Blue as "not a pure HMO but it is a hybrid HMO." If a *pure* HMO is an HMO then one can make the case that a *hybrid* HMO is an HMO. Both plans are managed care plans and the only difference to those enrolled is that if in the Point of Service plan there is some coverage if you go out of network but no coverage if you go out of network and are enrolled in the Keystone plan. Hinerman noted that the 95 percent of the coverage under the Point of Service plan has been in network.

If exceptions are filed to the decision and the Board concludes I am wrong and the Blue Cross-Blue Shield Point of Service plan is *not* an HMO then there may be a violation of the Act[1] but I see no need for a remedy, if that occurs, beyond the posting of a notice because:

1. Forty–two (42) of 110 employees voluntarily selected the Point of Service plan.

2. Any employee is free to switch into or back into any of the plans with no time limit and without regard to preexisting medical conditions.

3. There is no evidence of employee dissatisfaction with having the three options for health care made available to them since not one single employee, as of the date of the hearing before me, wanted to switch out of the Blue Cross-Blue Shield Point of Service plan.

Since the Respondent did not violate the Act by offering to the employees in the unit the Blue Cross-Blue Shield Point of Service plan it did not constitute unlawful direct dealing for the Respondent to have its personnel department advise the employees about this health insurance option.

CONCLUSIONS OF LAW

1. Sterling Lebanon Packaging Corporation is an employer engaged in commerce within the meaning of the Act.

2. United Steel Workers of America International Union, AFL–CIO, CLC, and its Local 175G are labor organizations within the meaning of Section 2(5) of the Act.

3. Respondent did not violate the Act as alleged in the complaint.

[1] See *Martin Marietta Energy,* 283 NLRB 173 (1987).

On these findings of fact and conclusions of law and on the entire record, I issue the following recommended[2]

ORDER

The complaint is dismissed in its entirety.

[2] If no exceptions are filed as provided by Sec. 102.46 of the Board's Rules and Regulations, the findings, conclusions, and recommended Order shall, as provided in Sec. 102.48 of the Rules, be adopted by the Board and all objections to them shall be deemed waived for all purposes.